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Office of Media Affairs

MEDICARE FACT SHEET

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PROPOSALS FOR IMPROVING QUALITY OF CARE DURING INPATIENT STAYS IN ACUTE CARE HOSPITALS IN THE FISCAL YEAR 2011 NOTICE OF PROPOSED RULEMAKING

OVERVIEW: On April 19, 2010, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would revise policies and payment rates for general acute care hospitals that are paid for inpatient services under the Inpatient Prospective Payment System (IPPS), effective for discharges in fiscal (FY) 2011 – that is, on or after October 1, 2010. In addition to promoting accurate payment for inpatient services to Medicare beneficiaries, the proposed rule strengthens the relationship between payment and quality of service by expanding the quality measures that hospitals must report in order to receive the full market basket update in fiscal year 2012. Under the Medicare law, hospitals that choose not to participate in the voluntary reporting program or do not participate successfully will receive an inflation update equal to the hospital market basket less two percentage points The proposed rule projects a market basket update of 2.4 percent, and, therefore, hospitals that do not successfully report the quality measures would receive updates currently projected to be 0.4 percent.

The proposed rule does not substantively change the list of hospital-acquired conditions (HACs) in FY 2011, but describes the results of CMS's evaluation of the impact of the existing policy on hospital practices and patient care.

This Fact Sheet discusses only the quality provisions of the IPPS FY 2011 proposed rule; separate fact sheets also issued today provide more detail on the payment and policy changes.

REPORTING HOSPITAL QUALITY DATA FOR ANNUAL PAYMENT UPDATE:

BACKGROUND: The Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) and HACs initiatives represent significant steps toward implementing value-based

purchasing (VBP) in Medicare. VBP is intended to transform Medicare from a passive payer for services to a prudent purchaser of services, paying not just for quantity of services but for quality as well.

The RHQDAPU Program grew out of the Hospital Quality Initiative developed by CMS in consultation with hospital groups. Participation in the program is voluntary, but after initial levels of participation proved disappointing, Congress added a financial incentive to the program in the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003. Under the MMA, hospitals that chose not to participate or failed to meet the criteria for successful reporting in a given year received the annual payment update (APU) reduced by 0.4 percentage points. The Deficit Reduction Act of 2005 increased this reduction to 2.0 percentage points. Since the implementation of the financial incentive, hospital participation has increased to 99 percent and, of participating hospitals, 96 percent are receiving the full APU in FY 2010.

In the meantime, the RHQDAPU measure set has grown from a starter set of 10 quality measures in 2004 to the current set of 46 quality measures. The 46 measures include 27 chart-abstracted measures (heart attack, heart failure, pneumonia, surgical care improvement), 15 claims-based measures (mortality and readmissions measures for heart attack, heart failure, pneumonia; AHRQ Patient Safety Indicators and Inpatient Quality Indicators; nursing sensitive care), 1 survey-based measure (patient satisfaction), and 3 structural measures (participation in a cardiac surgery, stroke care, and nursing sensitive care registry).

PROPOSED CHANGES TO THE RHQDAPU PROGRAM FOR THE FY 2012 FULL MARKET BASKET UPDATE: There are currently 46 quality measures for hospitals to report to receive the full market basket update. In this proposed rule for FY 2011, CMS is proposing to retire one of these RHQDAPU measures – Mortality for selected surgical procedures (composite) – and to add 10 new measures, bringing the total number of measures in the RHQDAPU measure set to 55 for reporting in 2011 for the FY 2012 market basket update. Specifically, CMS is proposing to add the following eight of the categories of conditions on the HAC list:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Pressure ulcer stages III and IV
- Falls and trauma (including fracture, dislocation, intracranial injury, crushing injury, burn, and electric shock)
- Vascular catheter-associated infection
- Catheter-associated urinary tract infection (UTI)
- Manifestations of poor glycemic control

In addition, CMS is proposing to add two more Patient Safety Indicators developed by the Agency for Healthcare Research and Quality – post-operative respiratory failure and post-operative pulmonary embolism or deep vein thrombosis. CMS is also proposing to add all patient volume data for selected MS-DRGs that relate to the RHQDAPU measures as a program requirement for the FY 2012 market basket update.

PROPOSED CHANGES IN THE FY 2011 PROPOSED RULE: Currently, for new measures, the data available for determining the APU may only reflect one-quarter's worth of discharges. CMS believes that it would facilitate more accurate data analysis, if there were at least one full year's worth of discharge data for each of the quality measures. Therefore, to synchronize the discharge quarter data so that at least four quarters of data from a single calendar year are used for an annual payment determination beginning with FY 2013, CMS is proposing in FY 2011 to adopt two sets of quality measures for reporting beginning January 1, 2011, but only one set would be used to determine the FY 2012 APU. Hospitals would be required to report the second set in 2011, but the data for these measures would be used to determine the FY 2013 APU, which is the first year that four quarters of data from a single calendar year would be used. CMS is also proposing a set of quality measures to be reported in 2012 for use in determining the FY 2014 APU.

CMS is proposing to add 10 measures for reporting in 2011 that will be used to determine the FY 2012 APU. CMS is proposing an additional 35 measures- many of which CMS is proposing to be reported through registries - for reporting in 2011 for use in determining the FY 2013 APU. If registry-based reporting is adopted, hospitals would report only on selected proposed registry-based measures. The proposed use of registries would prevent hospitals from having to report the same data twice. CMS is also proposing 4 new measures for reporting in 2012 that would be used in determining the FY 2014 APU. (See Appendix A for complete list of existing and proposed measures.)

Finally, the proposed rule identifies 28 additional measures for possible inclusion in future rulemaking cycles. (See Appendix B)

HOSPITAL-ACQUIRED CONDITIONS UPDATE

As required by the Deficit Reduction Act of 2005, CMS has implemented a payment policy to reduce Medicare payments in the event certain hospital-acquired conditions (HACs) occur during a Medicare beneficiary's inpatient stay. These HACs are conditions that that the agency has determined are reasonably preventable through adherence to evidence-based guidelines, are high cost and/or high volume, and result in higher payment. CMS has aggressively sought public input and worked with the Centers of Disease Control on evaluating and selecting these conditions. Beginning for discharges on or after October 1, 2008, CMS no longer pays at the higher MS-DRG if the only secondary diagnoses on a claim are on the HAC list and were not

reported as present at admission. To date, CMS has selected ten categories of conditions that are reasonably preventable, and that, when present as a secondary diagnosis at discharge, result in the case being assigned to a higher paying MS-DRG.

For FY 2010, CMS did not select any conditions for addition to the list, while it began a process to conduct a comprehensive evaluation of the policy's impact, working with other agencies within the Department of Health and Human Services - the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), and the Office of Public Health and Science (OPHS).

The proposed rule for FY 2011 does not include any new candidates to be considered for addition to the HAC list, but includes a discussion of the progress to date of the comprehensive evaluation, based on nine months of data in FY 2009. According to the preliminary analysis, the HAC policy resulted in payment adjustments for 3,038 discharges of 7.2 million total discharges during that time period for the 10 categories of conditions currently on the HAC list. These adjustments yielded a net savings of $16.4 million. CMS continues to believe that this policy plays an integral role in promoting quality of care and considers it to be part of an array of Medicare value-based purchasing (VBP) tools that CMS believes will promote increased quality and efficiency of care. Those tools include measuring performance, using payment incentives, publicly reporting performance results, applying national and local coverage policy decisions, enforcing conditions of participation, and providing direct support for providers through Quality Improvement Organization (QIO) activities. The application of VBP tools, such as this HAC provision, is transforming Medicare from a passive payer to an active purchaser of higher value health care services.

The evaluation is also looking at eight conditions that have been mentioned previously as possible candidates for inclusion on the HACs list, and has found 2,932 cases that would have been subject to the HACs policy - that is, the presence of the condition as a secondary diagnosis would have been the sole reason for payment at an enhanced rate if the condition had been on the HAC list. However, CMS does not believe that there is additional information at this time that would require a change to previous determinations regarding either current HACs or previously considered candidate HACs.

The final rule was placed on display at the *Federal Register* today, and can be found under Special Filings at:

www.archives.gov/federal-register/public-inspection/index.html.

For more information, please see:

www.cms.gov/AcuteInpatientPPS/01_overview.asp.

Appendix A

RHQDAPU PROGRAM CURRENT AND PROPOSED QUALITY MEASURES FOR REPORTING IN FY 2010 THROUGH FY 2013

Topic	Current and Proposed RHQDAPU Program Quality Measures for Reporting in FY 2010 through FY 2013	Current	Proposed	
			Reporting	For APU
Acute Myocardial Infarction (AMI)				
	• AMI-1 Aspirin at arrival	Yes		
	• AMI-2 Aspirin prescribed at discharge	Yes		
	• AMI-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction	Yes		
	• AMI-4 Adult smoking cessation advice/counseling	Yes		
	• AMI-5 Beta blocker prescribed at discharge	Yes		
	• AMI-7a Fibrinolytic (thrombolytic) agent received within 30 minutes of hospital arrival	Yes		
	• AMI-8a Timing of Receipt of Primary Percutaneous Coronary Intervention (PCI)	Yes		
	• Statin at discharge.		2011	FY 2013
Heart Failure (HF)				
	• HF-1 Discharge instructions	Yes		
	• HF-2 Left ventricular function assessment	Yes		
	• HF-3 Angiotensin Converting Enzyme Inhibitor (ACE-I) or Angiotensin II Receptor Blocker (ARB) for left ventricular systolic dysfunction	Yes		
	• HF-4 Adult smoking cessation advice/counseling	Yes		
Pneumonia (PN)				
	• PN-2 Pneumococcal vaccination status	Yes		

Topic	Current and Proposed RHQDAPU Program Quality Measures for Reporting in FY 2010 through FY 2013	Current	Proposed	
			Reporting	For APU
	• *PN-3b Blood culture performed before first antibiotic received in hospital*	*Yes*		
	• *PN-4 Adult smoking cessation advice/counseling*	*Yes*		
	• PN-5c Timing of receipt of initial antibiotic following hospital arrival	Yes		
	• PN-6 Appropriate initial antibiotic selection	Yes		
	• PN-7 Influenza vaccination status	Yes		
Surgical Care Improvement Project (SCIP)				
	• SCIP-1 Prophylactic antibiotic received within 1 hour prior to surgical incision	Yes		
	• SCIP-3 Prophylactic antibiotics discontinued within 24 hours after surgery end time	Yes		
	• SCIP-VTE-1: Venous thromboembolism (VTE) prophylaxis ordered for surgery patients	Yes		
	• SCIP-VTE-2: VTE prophylaxis within 24 hours pre/post surgery	Yes		
	• SCIP-Infection-2: Prophylactic antibiotic selection for surgical patients	Yes		
	• SCIP-Infection-4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose	Yes		
	• SCIP-Infection-6: Surgery Patients with Appropriate Hair Removal	Yes		
	• SCIP–Infection-9: Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2	Yes		
	• SCIP-Infection-10: Perioperative Temperature Management	Yes		
	• SCIP-Cardiovascular-2: Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period	Yes		

Topic	Current and Proposed RHQDAPU Program Quality Measures for Reporting in FY 2010 through FY 2013	Current	Proposed	
			Reporting	For APU
Mortality Measures (Medicare Patients)				
	• MORT-30-AMI: Acute Myocardial Infarction 30-day mortality –Medicare patients	Yes		
	• MORT-30-HF: Heart Failure 30-day mortality Medicare patients	Yes		
	• MORT-30-PN: Pneumonia 30-day mortality -Medicare patients	Yes		
Patients' Experience of Care				
	• HCAHPS survey	Yes		
Readmission Measure (Medicare Patients)				
	• READ-30-HF: Heart Failure 30-Day Risk Standardized Readmission Measure (Medicare patients)	Yes		
	• READ-30-AMI: Acute Myocardial Infarction 30-Day Risk Standardized Readmission Measure (Medicare patients)	Yes		
	• READ-30-PN: Pneumonia 30-Day Risk Standardized Readmission Measure (Medicare patients)	Yes		
AHRQ Patient Safety Indicators (PSIs), Inpatient Quality Indicators (IQIs) and Composite Measures				
	• PSI 06: Iatrogenic pneumothorax, adult	Yes		
	• PSI 14: Postoperative wound dehiscence	Yes		
	• PSI 15: Accidental puncture or laceration	Yes		
	• IQI 11: Abdominal aortic aneurysm (AAA) mortality rate (with or without volume)	Yes		
	• IQI 19: Hip fracture mortality rate	Yes		
	• Mortality for selected surgical procedures (composite)	Yes	Retire 2011	
	• Complication/patient safety for selected indicators (composite)	Yes		

Topic	Current and Proposed RHQDAPU Program Quality Measures for Reporting in FY 2010 through FY 2013	Current	Proposed	
			Reporting	For APU
	Mortality for selected medical conditions (composite)	Yes		
AHRQ PSI and Nursing Sensitive Care				
	• Death among surgical inpatients with serious, treatable complications	Yes		
Cardiac Surgery				
	Participation in a Systematic Database for Cardiac Surgery	Yes		
	Registry Based			
	• Post-operative Renal Failure	No	2011	FY 2013
	• Surgical Re-exploration	No	2011	FY 2013
	• Anti-Platelet Medication at Discharge	No	2011	FY 2013
	• Beta Blockade at Discharge	No	2011	FY 2013
	• Anti-Lipid Treatment Discharge	No	2011	FY 2013
	• Risk-Adjusted Operative Mortality for Coronary Artery Bypass Graft CABG	No	2011	FY 2013
	• Risk-Adjusted Operative Mortality for Aortic Valve Replacement (AVR)	No	2011	FY 2013
	• Risk-Adjusted Operative Mortality for Mitral Valve Replacement/Repair (MVR)	No	2011	FY 2013
	• Risk-Adjusted Operative Mortality MVR+CABG Surgery	No	2011	FY 2013
	• Risk-Adjusted Operative Mortality for AVR+CABG	No	2011	FY 2013
	• Pre-Operative Beta Blockade	No	2011	FY 2013
	• Duration of Prophylaxis for Cardiac Surgery Patients	No	2011	FY 2013
	• Prolonged Intubation (ventilation)	No	2011	FY 2013
	• Deep Sternal Wound Infection Rate	No	2011	FY 2013
	• Stroke/Cerebrovascular Accident	No	2011	FY 2013
Stroke Care				
	Participation in a Systematic Clinical Database Registry for Stroke Care	Yes		

Topic	Current and Proposed RHQDAPU Program Quality Measures for Reporting in FY 2010 through FY 2013	Current	Proposed	
	Registry Based Measures			
	• STK-1: Venous Thromboembolism (VTE) Prophylaxis for patients with ischemic or hemorrhagic stroke	No	2011	FY 2013
	• STK-2: Ischemic stroke patients discharged on antithrombotic therapy.	No	2011	FY 2013
	• STK-3: Anticoagulation therapy for atrial fibrillation/flutter.	No	2011	FY 2013
	• STK-4: Thrombolytic Therapy for Acute ischemic stroke patients.	No	2011	FY 2013
	• STK-5: Antithrombotic therapy by the end of hospital day two.	No	2011	FY 2013
	• STK-6: Discharged on statin medication.	No	2011	FY 2013
	• STK-8: Stroke education.	No	2011	FY 2013
	• STK-10: Assessed for rehabilitation services.	No	2011	FY 2013
Nursing Sensitive Care				
	Participation in a Systematic Clinical Database Registry for Nursing Sensitive Care	Yes		
	Registry Based Measures			
	• Patient Falls: All documented falls with or without injury, experienced by patients on an eligible unit in a calendar month.	No	2011	FY 2013
	• Falls with Injury: All documented patient falls with an injury level of minor or greater.	No	2011	FY 2013
	• Pressure Ulcer Prevalence	No	2011	FY 2013
	• Restraint Prevalence (vest and limb)	No	2011	FY 2013
	• Skill Mix: Percentage of hours worked by: RN, LPN/LVN, UAP, Contract/Agency	No	2011	FY 2013
	• Hours per patient day worked by RN, LPN, and UAP	No	2011	FY 2013

Topic	Current and Proposed RHQDAPU Program Quality Measures for Reporting in FY 2010 through FY 2013	Current	Proposed	
			Reporting	For APU
	• Practice Environment Scale-Nursing Work Index	No	2011	FY 2013
	• Voluntary turnover for RN, APN, LPN, UAP	No	2011	FY 2013
Hospital Acquired Condition (HAC) Rates				
	• Foreign Object Retained After Surgery	No	2011	FY 2012
	• Air Embolism	No	2011	FY 2012
	• Blood Incompatibility	No	2011	FY 2012
	• Pressure Ulcer Stages III & IV	No	2011	FY 2012
	• Falls and Trauma: (Includes: Fracture Dislocation Intracranial Injury Crushing Injury Burn Electric Shock)	No	2011	FY 2012
	• Vascular Catheter-Associated Infection	No	2011	FY 2012
	• Catheter-Associated Urinary Tract Infection (UTI)	No	2011	FY 2012
	• Manifestations of Poor Glycemic Control	No	2011	FY 2012
	• Central Line Associated Bloodstream Infection	No	2011	FY 2013
	• Surgical Site Infection	No	2011	FY 2013
AHRQ Patient Safety Indicators (PSIs)				
	PSI -11: Post Operative Respiratory Failure	No	2011	FY 2012
	PSI – 12: Post Operative PE or DVT	No	2011	FY 2012
ICD Complications -- Registry Based				
	ICD Complications and Mortality	No	2011	FY 2013
Emergency Department Throughput				
	• Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status.	No	2012	FY 2014

Topic	Current and Proposed RHQDAPU Program Quality Measures for Reporting in FY 2010 through FY 2013	Current	Proposed	
			Reporting	For APU
	• Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department.	No	2012	FY 2014
Global Immunization				
	Immunization for Influenza	No	2012	FY 2014
	Immunization for Pneumonia	No	2012	FY 2014

All-Patient Volume Data for Selected DRGs (55)	
	MS-DRGs: 038; 039; 190; 191; 193; 219; 220; 221; 224; 226; 235; 236; 237; 243; 247; 280; 281; 282; 291; 292; 293; 328; 329; 330; 331; 353; 354; 417; 418; 459; 461; 462; 466; 467; 468; 469; 470; 471; 472; 477; 478; 490; 507; 515; 656; 657; 658; 659; 668; 673; 674; 675; 713; 743; 748

Appendix B

MEASURES FOR CONSIDERATION FOR FUTURE RULEMAKING PROCEEDINGS

Measure Topic	Measure Description
Surgical Safety	Surgical checklist use for surgical procedures
Complications	Lower Extremity Bypass Complications
PCI Readmission	30-day risk-standardized readmission rate following Percutaneous Coronary Intervention (PCI) among patients aged 18 years or older.
PCI Mortality	30-day risk-standardized mortality rate following PCI for STEMI/shock patients.
PCI Mortality	30-day risk-standardized mortality rate following PCI for non-STEMI/non-shock patients.
VTE	VTE-1: Venous Thromboembolism Prophylaxis
VTE	VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis
VTE	VTE-3: Venous Thromboembolism Patients with Anticoagulation Overlap Therapy
VTE	VTE-4: Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/Platelet Count Monitoring by Protocol
VTE	VTE-5: Venous Thromboembolism Discharge Instructions
VTE	VTE-6: Incidence of Potentially-Preventable Venous Thromboembolism.
SCIP	Short Half-Life prophylactic administered preoperatively redosed within 4 hours after preoperative dose
Care Transitions for AMI	30-Day Post-Hospital AMI Discharge ED Visit Measure
Care Transitions for AMI	30-Day Post-Hospital AMI Discharge Evaluation and Management Service Measure
Care Transitions for AMI	30-Day Post-Hospital AMI Discharge Care Transition Composite Measure
Care Transitions for Heart Failure	30-Day Post-Hospital HF Discharge ED Visit Rate
Care Transitions for Heart Failure	30-Day Post-Hospital HF Discharge Evaluation and Management Service Measure
Care Transitions for Heart Failure	30-Day Post-Hospital HF Discharge Care Transition Composite Measure
Care Transitions for Pneumonia	30-Day Post-Hospital Pneumonia Discharge ED Visit Rate

Measure Topic	Measure Description
Care Transitions for Pneumonia	30-Day Post-Hospital Pneumonia Discharge Evaluation and Management Service Measure
Care Transitions for Pneumonia	30-Day Post-Hospital Pneumonia Discharge Care Transition Composite Measure
Healthcare Associated Infections	Ventilator Associated Pneumonia, CDC
Healthcare Associated Infections	Catheter Associated UTI, CDC
Healthcare Associated Infections	Multidrug-resistant organism (MDRO) infection
Healthcare Associated Infections	Clostridium Difficile Associated Diseases (CDAD)
Health Care Personnel Immunization	Influenza Vaccination for Healthcare Personnel
Cardiac Rehabilitation Referral	Cardiac Rehabilitation Referral for AMI, HF, Cardiac Surgery
End of Life Care	Pain Management

The proposed rule went on display today at the Office of the Federal Register's Public Inspection Desk and will be available as a special filing at:

www.federalregister.gov/inspection.aspx.

CMS will accept comments on this proposed rule until June 18, and will respond to them in a final rule to be issued by August 1, 2010.

For more information, please see:

www.cms.gov/AcuteInpatientPPS/01_overview.asp.

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